AODA DAY TREATMENT
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A. TYPE OF HANDBOOK

Divison IV, Alcohol and Other Drug Abuse (AODA) Day Treatment, is the service specific portion of the Wisconsin Medical Assistance Provider Handbook. It is the fourth division of Part H of the Mental Health Handbook, which includes all information for mental health services. Division IV includes information for AODA day treatment providers regarding provider eligibility criteria, recipient eligibility criteria, covered services, reimbursement rates, and billing instructions. Division IV is intended to be used in conjunction with Part A of the Wisconsin Medical Assistance Provider Handbook which includes general policy guidelines, regulations, and billing information applicable to all types of providers certified in the Wisconsin Medical Assistance Program (WMAP).

B. PROVIDER INFORMATION

Provider Eligibility and Certification

In order to be reimbursed by the WMAP for providing AODA day treatment, a provider must be certified as an outpatient treatment facility or a hospital and must satisfy three different certification requirements:

- The provider must be certified by the Wisconsin Division of Community Services for AODA day treatment under HSS 61.61.
- The provider must be certified by the WMAP under HSS 105.23 as an AODA treatment provider; and
- The provider must be certified by the WMAP to provide AODA day treatment under HSS 105.25.

In order to receive certification under HSS 105.25, a provider must demonstrate that all individuals who will provide AODA day treatment services for WMAP recipients either (1) meet professional certification standards for their areas of specialization (e.g., education and experience requirements for certified AODA counselors); or (2) provide services under the supervision of a qualified professional staff member (e.g., master's degree mental health professional, certified AODA counselors).

To obtain information regarding certification under HSS 61.61, providers must contact:

Program Certification Unit
Division of Community Services
Post Office Box 7851
Madison, WI 53707
(608) 266-0120

To obtain an application for receiving WMAP certification under HSS 105.23 and 105.25, providers must contact:

E.D.S. Federal Corporation
Attn: Provider Maintenance
6406 Bridge Road
Madison, WI 53784-0006

Section HSS 101.03(142), Wis. Adm. Code, states that the first day on which a provider may begin participation in the WMAP (i.e., certification effective date) must be no earlier than (and may be later than) the initial date of application. "Initial date of application" is defined as the date a written or telephone request for an application is received by the Department of Health and Social Services or E.D.S. Federal Corporation (EDS) from the prospective provider. To receive the earliest certification effective date allowed under this provision, the provider must return a complete and acceptable application for processing within 30 days from the date the materials are mailed to the provider. Applications returned after the 30-day period will result in assignment of a

B. PROVIDER NOTIFICATION (continued)

certification effective date based on the date a complete application is received by EDS. This policy only applies if all applicable licensure and certification criteria are met at the time the request for certification is received by EDS. If licensure and certification requirements are not met at the time of application, certification will be delayed until all licensure and/or certification requirements have been satisfactorily completed. This could result in assignment of a later certification effective date. No claims for dates of service prior to the effective date of certification will be paid.

WMAP-certified AODA day treatment providers will be issued an eight-digit provider number which ends with "21." All AODA day treatment services must be billed under the provider number with the "21" suffix.

Scope of Service
The policies in Division IV govern all AODA day treatment services provided within the scope of the practice of the profession as defined in ss. 49.46(2)(b)6.f, Wis. Stats. and Wis. Adm. Code Chapter HSS 107.13(3m). Covered services and related limitations are enumerated through Sections II, III, IV, and V of this handbook.

Billed Amount
An AODA day treatment provider must bill the WMAP the usual and customary charge (the fee normally charged to private pay patients for services). For providers using a sliding fee scale for specific services, usual and customary means that median of the individual provider's charge for the service when provided to non-Medical Assistance patients.

Providers should refer to Section II of this handbook for valid procedure codes and to Section IV of this handbook for further billing instructions.

Terms of Reimbursement
AODA day treatment providers will be reimbursed on the basis of an hourly rate. Separate rates have been established for hours spent on the assessment of the recipient and for hours spent in the actual AODA day treatment program.

AODA day treatment services are reimbursed on the basis of usual and customary charges, up to a WMAP established maximum fee for each procedure. Payment is based on the usual and customary charges or the maximum fee, whichever is less.

Provider Responsibilities
Specific responsibilities as a provider under the WMAP are stated in Section IV of Part A of the WMAP Provider Handbook. This section should be referenced for detailed information regarding fair treatment of the recipient, maintenance of records, recipient requests for noncovered services, services rendered to a recipient during periods of retroactive eligibility, grounds for provider sanctions, and additional state and federal requirements.

C. RECIPIENT INFORMATION

Eligibility For Medical Assistance
Recipients meeting eligibility criteria for Medical Assistance are issued Medical Assistance identification cards. The identification cards include the recipient's name; date of birth; 10-digit Medical Assistance identification number; medical status code; and an indicator of private health insurance coverage, HMO coverage, and/or Medicare coverage.

Medical Assistance identification cards are sent to recipients on a monthly basis. All Medical Assistance identification cards are valid only through the end of the month in which they are issued. It is important that the provider or the designated agent check a recipient's Medical Assistance identification card prior to providing service to determine

C. RECIPIENT INFORMATION (continued)

if the recipient is currently eligible and if there are any limitations to the recipient's coverage.

Section V-C of Part A of the WMAP Provider Handbook provides detailed information regarding eligibility for Medical Assistance, Medical Assistance identification cards, temporary cards, restricted cards, and how to verify eligibility. Section V-C of Part A must be reviewed carefully by the provider before services are rendered. A sample Medical Assistance identification card can be found in Appendix 7 of Part A of the WMAP Provider Handbook.

Medical Category
Medical Assistance recipients are classified into one of two eligibility categories, either medically needy or categorically needy. These categories allow for a differentiation of benefit coverage. AODA day treatment services are available to categorically needy WMAP recipients who are not hospital inpatients or nursing home residents.

AODA day treatment services are only a benefit for medically needy recipients when referred for services by a HealthCheck provider. (HealthCheck is a program which provides all WMAP eligible recipients under 21 years old with regular examinations.) Providers can identify medically needy recipients by two asterisks (**) preceding the recipient's 10-digit Medical Assistance identification number on the Medical Assistance identification card.

Copayment
AODA day treatment services are exempt from copayment.

HMO Coverage
WMAP recipients enrolled in WMAP-contracted HMOs receive a yellow Medical Assistance identification card. This card has a six-character code in the "Other Coverage" column designating the recipient's HMO. These codes are defined in Appendices 20, 21, and 22 of Part A of the WMAP Provider Handbook.

Providers must always check the recipient's current Medical Assistance identification card for HMO coverage before providing services. AODA day treatment is a WMAP-contracted HMO covered service. Certified AODA treatment providers must receive prior authorization from a WMAP recipient's HMO before providing services. Claims submitted to EDS for services covered by WMAP-contracted HMOs will be denied.

For recipients enrolled in a WMAP-contracted HMO, all conditions of reimbursement and prior authorization for AODA day treatment will be established by the contract between the HMOs and certified providers.

A. INTRODUCTION

The Wisconsin Medical Assistance Program (WMAP) coverage of alcohol and other drug abuse (AODA) day treatment was instituted by the Wisconsin Legislature in 1987 Act 339, in order to enhance the outpatient AODA services available to categorically needy WMAP recipients.

AODA day treatment is an appropriate and effective mode of treatment for a variety of recipients. Characteristically, AODA day treatment patients are persons likely to suffer imminent relapse into alcohol or other drug abuse unless they receive outpatient treatment with the structure and intensity provided by AODA day treatment. They are persons whose lives are adversely affected by their chemical abuse, with disruption of social, behavioral, or vocational functioning caused by chemical use. The recipient may have psychological or physical conditions which make AODA day treatment structure and intensity necessary for effective care; yet, these problems must not be of a severity which indicates that inpatient care is required (refer to Appendices 1 and 2 of this handbook for criteria). Usually, prior to requiring AODA day treatment services, lower levels of care have been attempted (such as outpatient counseling one or two hours per week) and have proven ineffective in maintaining sobriety for the individual.

For admission to an AODA day treatment program, a recipient must be detoxified from drugs or alcohol, have the ability to function in a semicontrolled medically supervised environment, have a demonstrated need for structure and intensity of treatment which is not available in outpatient treatment, and be willing to participate in aftercare upon completion of treatment.

B. COVERED SERVICES

AODA day treatment consists of medically prescribed treatments provided by AODA and related medical professionals (such as mental health counselors, physicians, psychiatrists, nurses, and occupational therapists) in a medically supervised outpatient setting. AODA day treatment services must be provided in a certified AODA day treatment program as discussed in Section I-B of this handbook. This program must be structured to provide a minimum of 60 hours of intensive direct treatment for a minimum of 10 hours a week, for a period not more than six weeks. Under extenuating circumstances such as sickness, vacation, or inclement weather, the treatment period may last up to eight weeks. AODA day treatment is provided under an individual plan of care developed by an interdisciplinary team in conjunction with the recipient, a physician, and, as appropriate, with the recipient's family. Included in treatment may be evaluation, treatment planning, group and individual counseling, recipient education when necessary for effective treatment, and rehabilitative services. (Refer to Appendices 1 and 2 of this handbook.)

The following procedures are covered under AODA day treatment:

1. Assessment (Procedure Code W8980). The first three hours of assessment and evaluation per recipient per provider in a calendar year regarding the need for and ability to benefit from AODA day treatment.

2. Assessment - Limitation Exceeded (Procedure code W8981). Additional hours spent in assessment and evaluation after the initial three hours of assessment have been provided in a calendar year.

3. AODA Day Treatment (Procedure code W8982). Intensive short-term AODA treatment provided on an outpatient basis by a hospital or outpatient facility certified under HSS 105.25.

C. NONCOVERED SERVICES

The following services are not covered benefits of the WMAP:

1. AODA day treatment assessment and services provided to medically needy recipients, except under a HealthCheck referral for recipients under 21 years old.

2. AODA day treatment services performed without prior authorization when required (see Section III of this handbook for prior authorization discussion.).

3. AODA day treatment services billed under any other treatment modality, including AODA outpatient services, psychotherapy, occupational therapy, or case management.

4. AODA day treatment services which are primarily recreational, social or only educational in nature, including time devoted to meals, rest periods, transportation, or entertainment.

5. AODA day treatment services provided in a setting other than outpatient hospital or outpatient clinic, including the recipient's home.

6. Time spent in AODA day treatment by affected family members of the recipient.

7. AODA day treatment given in excess of five hours a day.

8. AODA day treatment is <u>not</u> a reimbursable benefit for hospital inpatients or nursing home residents. For inpatients or nursing home residents who need such treatment, AODA day treatment services are reimbursed through the per-discharge or per-diem rate paid to hospitals and nursing homes.

A. GENERAL REQUIREMENTS

Prior authorization procedures are designed to safeguard against unnecessary utilization of care, to promote the most effective and appropriate use of available services, and to assist in cost containment. Providers are required to seek prior authorization for certain specified services before delivery of that service, unless the service is provided on an emergency basis. Payment will not be made for services provided either prior to the grant date or after the expiration date indicated on the approved prior authorization request form. If the provider renders a service which requires prior authorization without first obtaining authorization, the provider is responsible for the cost of the service. (See Section III-E of this handbook for exceptional situations.)

Particular scrutiny will be given to prior authorization requests for recipients who have received inpatient or other intensive outpatient AODA services within the past 12 months to ensure that further intensive treatment will be appropriate and effective for the recipient.

B. SERVICES REQUIRING PRIOR AUTHORIZATION

Prior authorization requirements for the allowable AODA day treatment procedures are discussed below.

1. Assessment (Procedure code W8980). The first three hours of assessment per recipient per provider in any calendar year do not require prior authorization and are not part of either the day treatment authorization or the mental health prior authorization limits.

2. Assessment - Limitation Exceeded (Procedure code W8981). Limitation-exceeded assessment hours must be prior authorized by the Wisconsin Medical Assistance Program (WMAP).

3. AODA Day Treatment (Procedure code W8982). All AODA day treatment must be prior authorized by the WMAP.

Providers are advised that prior authorization does not guarantee payment. Provider eligibility, recipient eligibility, and medical status on the date of service as well as all other WMAP requirements must be met prior to payment of the claim.

C. PRIOR AUTHORIZATION CRITERIA

Prior authorization criteria for intensity of treatment and severity of illness have been developed for AODA day treatment by the WMAP and AODA providers. Appendices 1 and 2 of this handbook contain treatment criteria for AODA day treatment services for adults and adolescents. When assessing recipients 18 to 21 years old, providers are to use the adult or adolescent criteria depending on the individual recipient's circumstances. Providers must refer to the appropriate treatment criteria when requesting prior authorization. The criteria illustrate the factors which will be used in determining whether AODA day treatment is considered medically necessary by the WMAP.

D. PROCEDURES FOR OBTAINING PRIOR AUTHORIZATION

Section VIII-D of Part A of the WMAP Provider Handbook identifies procedures for obtaining prior authorization including emergency situations, appeal procedures, supporting materials, retroactive authorization, recipient loss of eligibility midway in treatment, and prior authorization for out-of-state providers.

Providers must use both the Prior Authorization Request Form (PA/RF) and the Prior Authorization AODA Day Treatment Attachment (PA/ADTA) for limitation-exceeded AODA day treatment assessment (W8981) and AODA day treatment (W8982). Examples of the appropriate prior authorization request forms, along with completion and submittal instructions, are included in Appendices 3, 4, 5, and 6 of this handbook. Appendices 1 and 2 of this handbook contain criteria for prior authorizations which must be justified with the PA/ADTA.

D. PROCEDURES FOR OBTAINING PRIOR AUTHORIZATION (continued)

Prior authorization requests for AODA day treatment must be made under the eight-digit provider number which ends in 21 or they will be returned to the provider.

Completed prior authorization request forms must be submitted to:

E.D.S. Federal Corporation
Attn: Prior Authorization Unit - Suite 88
6406 Bridge Road
Madison, WI 53784-0088

Prior authorization request forms can be obtained by submitting a written request to:

E.D.S. Federal Corporation
Attn: Claim Reorder Department
6406 Bridge Road
Madison, WI 53784-0003

Please specify the form requested and the number of forms desired. Reorder forms are included in the mailing of each request for forms. Do not request forms by telephone.

E. INITIAL DATE OF PRIOR AUTHORIZATION

Originally, prior authorization must be obtained before AODA day treatment services are performed. However, in the case of provider or recipient retroactive eligibility or provision of a service requiring prior authorization which was performed on an emergency basis, retroactive authorization may be provided.

The WMAP recognizes that in certain cases it is medically necessary to start the recipient in AODA day treatment within a relatively short period of time of initial assessment or completion of detoxification. The WMAP will allow backdating up to five working days prior to the date EDS receives the request if:

a. The prior authorization request specifically requests backdating;

b. The clinical justification for beginning the AODA day treatment program before prior authorization is obtained is included in the Prior Authorization AODA Day Treatment attachment (PA/ADTA);

c. The request is received by EDS within five working days of the start of treatment; and

d. All other criteria are met (see Appendices 1 and 2 of this handbook).

In all other cases, the grant date will be determined by information given by the provider on the PA/ADTA.

A. OTHER THIRD PARTY LIABILITY (TPL) COVERAGE

The Wisconsin Medical Assistance Program (WMAP) is the payer of last resort for any service covered by the WMAP. If the recipient is covered under third party insurance, the WMAP reimburses that portion of the allowable cost remaining after all other third party sources have been exhausted. Refer to Section IX-D of Part A of the WMAP Provider Handbook for more detailed information on services requiring third party billing, exceptions, and the "Other Insurance Discrepancy Report."

B. MEDICARE/ MEDICAL ASSISTANCE DUAL ENTITLEMENT

Recipients covered under both Medicare and Medical Assistance are referred to as dual-entitlees. Claims for Medicare covered services provided to dual-entitlees must be billed to Medicare prior to billing Medical Assistance. AODA day treatment is not a Medicare-covered service, and thus billing Medicare for dual entitlees is not required. However, a Medicare disclaimer code must be indicated on the claim, if the recipient has Medicare, as indicated in the claim form instructions in Appendix 7 of this handbook.

C. BILLED AMOUNTS

Providers are required to bill their usual and customary charges when rendering an identical service to WMAP recipients and to private pay recipients. Providers must not discriminate against recipients by charging a higher fee for the same service than is charged to a private pay patient.

AODA day treatment assessment and services will be reimbursed based on an hourly rate, per recipient, on the basis of the provider's usual and customary charge or a maximum fee, whichever is less.

Hospitals which are certified AODA day treatment providers must establish a nonreimbursable cost center in their cost reports for this service. As providers, hospitals will be paid by the hour for AODA day treatment according to the maximum allowable fee schedule.

D. CLAIM SUBMISSION

Paper Claim Submission

AODA day treatment services must be submitted using the National HCFA 1500 claim form dated 12/90. A sample claim form and completion instructions can be found in Appendices 7 and 8 of this handbook.

AODA day treatment services submitted on any other form than the National HCFA 1500 claim form will be denied.

The National HCFA 1500 claim form is not provided by the WMAP or EDS. It may be obtained from a number of forms suppliers. One such source is:

State Medical Society Services
Post Office Box 1109
Madison, WI 53701
(608) 257-6781 (Madison area)
1-800-362-9080 (toll-free)

Completed claims submitted for payment must be mailed to the following address:

EDS
6406 Bridge Road
Madison, WI 53784-0002

D. CLAIM SUBMISSION (continued)

Paperless Claim Submission

As an alternative to submission of paper claims, EDS is able to process claims submitted on magnetic tape (tape-to-tape) or through telephone transmission via modem. Claims submitted electronically have the same legal requirements as claims submitted on paper and will be subjected to the same processing requirements as paper claims. Providers submitting electronically can usually reduce their claim submission errors. Additional information on alternative claim submission is available by contacting:

EDS
Attn: EMC Department
6406 Bridge Road
Madison, WI 53784-0009
(608) 221-4746

Submission of Claims

All claims for services rendered to eligible WMAP recipients must be received by EDS within 365 days from the date the service was rendered. Claims for coinsurance and deductible for services rendered to recipients covered by both Medicare and Medical Assistance must be received by EDS within 365 days from the date of service, *or* within 90 days from the Medicare EOMB date, whichever is later. (Refer to Section IX of Part A of the WMAP Provider Handbook for exceptions to the 90-day extension.) This policy applies to all initial claim submissions, resubmissions, and adjustment requests.

E. DIAGNOSIS CODES

All AODA day treatment claims for procedure code W8982 (AODA day treatment) must have a primary diagnosis of one of the following ICD-9-CM (International Classification of Diseases, 9th Edition, Clinical Modifications) codes:

303.9	alcohol dependence
304.0-304.9	drug dependence
305.0	alcohol abuse
305.2-305.9	alcohol and other drug abuse

Claims received without the appropriate ICD-9-CM code will be denied.

The complete ICD-9-CM code book can be ordered from:

ICD-9-CM
Post Office Box 991
Ann Arbor, MI 48106

Providers should note the following diagnosis code restrictions:

- Codes with an "E" prefix must not be used as the primary or sole diagnosis on a claim submitted to the WMAP.

- Codes with an "M" prefix are not acceptable on a claim submitted to the WMAP.

F. PROCEDURE CODES

HCFA Common Procedure Coding System (HCPCS) codes are required on all CSP claims. Claims or adjustments received without HCPCS codes are denied. Allowable HCPCS codes for CSP are included in Appendix 7 of this handbook.

G. FOLLOW-UP TO CLAIM SUBMISSION

It is the responsibility of the provider to initiate follow-up procedures on claims submitted to EDS. Processed claims appear on the Remittance and Status Report either as paid, pending, or denied. Providers are advised that EDS will take no further action on a denied claim until the information is corrected and the claim is resubmitted for processing. If a claim was paid incorrectly, the provider is responsible for submitting an adjustment request form to EDS. Section X of Part A of the WMAP Provider Handbook includes detailed information regarding:

- the Remittance and Status Report
- adjustments to paid claims
- return of overpayments
- duplicate payments
- denied claims
- Good Faith claims filing procedures